Let’s Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Health Zone

Nurse Practitioner-Led Clinic

3/30/2019

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Health Zone Nurse Practitioner-Led Clinic is now in its seventh year of clinical operation. As outlined in our mission, vision, and value statement we aim to serve the population in the city of London and surrounding areas. We have a particular focus on women and children in transition, newcomers, and those living in marginalized conditions. A large percentage of our population have experienced complex trauma; most of whom have difficulty accessing traditional models of healthcare. In fact, in the 2018-2019 year we rostered 50 new patients, many of whom had been on the provincial waitlist (Health Care Connect) for a family physician for one or more years; or were newcomers to Canada. We are now providing long-term primary care for these individuals.

In line with the population we serve, at Health Zone we provide a holistic model of care that includes compassion, flexibility, and most importantly, the time for our patients to voice their concerns. In fact, 3 or more health concerns were addressed within a single NP clinic visit 33% of the time, and 5 or more concerns were addressed in 7% of all NP clinic visits from 2018-2019. Furthermore, 30% of all adult rostered patients were seen by an NP and two other team members (i.e. two of registered nurse, social work, or dietitian) over the last year. Considering the complexity of the primary care population we serve, the additional time and multidisciplinary involvement is essential to minimize mental health and chronic disease complications, and to prevent and decrease emergency room visits. In terms of newcomer health, overall, 8% of our rostered clients do not have English as first language and require translator services for clinic visits. We also support these clients with case management, and translators for specialty appointments; to prevent unnecessary emergency room visits and provide a comprehensive high standard of care.

Describe your organization's greatest QI achievement from the past year

The new Canadian hepatitis C virus (HCV) guidelines were released in June 2018 by the Canadian Association for Study of the Liver. In this guideline two major themes were introduced: birth cohort screening (those born between 1945-1975), and the need for increased screening and treatment in primary care. In addition to birth cohort screening, Health Zone serves many priority populations affected by HCV including newcomers to Canada, individuals with a current or past history of drug use, and children born to HCV-positive mothers.

The introduction of all-oral direct acting antivirals in addition to the provincial elimination of liver disease criteria for treatment coverage, has revolutionized the potential scale and scope of HCV elimination in the community. Treatment is well tolerated, with minimal side-effects and has high cure rates (95%+). A recent US study demonstrated that although visits to primary care following a positive HCV result are increasing and greatly exceed specialty; treatment initiation remains low. Yet, clinical trial data demonstrates that once treatment is initiated, cure rates are significantly higher; with appointment adherence highest among NP-treaters. This is largely been attributed to NPs practicing from a holistic framework, spending more time with patients per visit, and accommodating walk-ins. NPs currently prescribe HCV therapy in Ontario in the community; thus, the aim of this QIP was to assess the feasibility of a systematic approach to achieve an HCV-free NPLC.

In July 2018, the Health Zone team received a 1.5 hour training to review current screening guidelines, and develop an approach to track screening and treatment; with one on-site more experienced HCV treater, and hepatology consult if needed. Over the last year, the nurse practitioners have screened 57.2% of the indicated population, with a 5% positivity rate among those tested; in comparison to the Canadian national average which is approximately 1%. Twenty pediatric screening

tests were also completed for children born in endemic countries, or born to HCV-positive mothers. To date, the clinic has successfully achieved cure for 33% of individuals, with no adverse events, and no treatment failures. 66% of other individuals are currently engaged in HCV care.

Our QIP demonstrates that using a formalized approach to screen and treat those cared for within a NPLC is an effective way to case-find HCV-positive individuals in primary care. We also demonstrate that HCV care delivered by an NPLC is safe and effective.

Patient/client/resident partnering and relations

Over the past year, we have been unable to formally collect patient satisfaction data. However, when we transition to PS Suites, we will integrate Ocean in order to collect these data seamlessly. We do however, informally hold space at the beginning and end of each patient visit for feedback and suggestions for improvement. In contrast to the results from the 2017-2018 aggregate data at the provincial level, our patients have never suggested that they do not have enough time within their appointments to have their major concerns addressed. This is an overarching strength of our organization.

Workplace violence prevention

Each year we review and refine our employee safe space policy to broaden definitions and clearly outline employee expectations.

Contact Information

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Other

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

In line with our holistic model of care, we emphasize the benefits of non-pharmacologic interventions, and non-opioid therapeutic options. Although we have the knowledge, skill, and judgement to safely prescribe opioids, we recognize that pain is multimodal, and especially among our population, largely tied to mental health; putting our clients at risk for opioid use disorder. We completed a chart review for 2018-2019 and among our adult population only 0.27% of all rostered clients were prescribed an opioid, 0.18% of which were only prescribed short course (less than 2 months). Thus, <0.2% of our adults rostered patients are on long-term opioid therapy. In these circumstances, we are working with both pain and addictions physicians to improve their pain management and continue to titrate their opioid.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Gina Palmese _______________ (signature)
Quality Committee Chair or delegate Mia Biondi, NP-PHC _______________ (signature)
Executive Director/Administrative Lead Gail McMahon _______________ (signature)
Other leadership as appropriate _______________ (signature)

2019/20 Quality Improvement Plan for Ontario Primary Care "Improvement Targets and Initiatives"

Health Zone P.O. Box 25087

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	Efficient	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	92327*	CB	90.00	To date we have not been able to easily export these data from our EMR. Following our EMR transition, we hypothesize that of the discharge notices we receive, our percentage of patients who receive follow-up care will be high as our clinicians prioritize contacting these clients within 1-2 days of receiving a report.		1)On April 3, 2019 we are transitioning our EMR and will create a "stamp" for 7-day post hospital discharge follow up for selected conditions. These will be reviewed weekly, so ensure patients discharged the previous week have been reviewed.	RN and NP QIP committee representatives will be responsible for this measure. 1. NPs and RNs (or those covering) to review EMR dashboards daily for hospital discharge reports, which will be filed. 2. Determine if admission meets criteria for 7-day post hospital follow up. 3. MOAs to book patient same day discharge report reviewed.	Number of patients discharged for select conditions who receive 7-day post hospital discharge follow-up appointment will be reviewed each month. Matched discharge reports and confirmed encounters will be assessed.	90% of patients discharged for select conditions will receive a 7-day post hospital discharge follow-up appointment between April 1 2019-April 1 2020.	
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12-month period.	92327*	CB	90.00	To date we have not been able to easily export these data from our EMR. Following our EMR transition, we hypothesize that of the discharge notices we receive, our percentage of patients who receive follow-up care will be high as our clinicians prioritize contacting these clients within 1-2 days of receiving a report.		1)On April 3, 2019 we are transitioning our EMR and will create a "stamp" for 7-day post hospital discharge follow up for any condition. These will be reviewed weekly, so ensure patients discharged the previous week have been reviewed.	RN and NP QIP committee representatives will be responsible for this measure. 1. NPs and RNs (or those covering) to review EMR dashboards daily for hospital discharge reports, which will be filed. 2. Determine if admission reason and discharge summary requires phone or in-clinic follow-up. 3. If phone, follow-up delegated to RN to be completed within 7 days. 4. If clinic visit indicated, MOAs to book patient for appointment within 48 hours of NP receiving notification.	Number of patients discharged for select conditions who receive 7-day post hospital discharge follow-up will be reviewed each month. Matched discharge reports and confirmed encounters will be assessed.	90% of patients discharged for any conditions will receive a 7-day post hospital discharge follow-up by any mode between April 1 2019-April 1 2020.	
	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92327*	CB	60.00	Most patients at our clinic are appropriately triaged through our registered nurses. However, at times clients do attend walk-ins or urgent care. To date we have not been able to easily export these data from our EMR. Following our EMR transition, we plan to be able to track clients require same day appointments following triage, and report as a percentage of all requests.		1)On April 3, 2019, we are transitioning our EMR. As a result we will have the opportunity to create custom stamps that include hyperlinked assessment types. We intend to create two such stamps: 1) for the triage process, and 2) for those who who require a same day/next day, and 3) those who are seen in clinic for same-day/next-day.	RN and NP QIP committee representatives will be responsible for this measure. 1. All same day appointment requests will be triaged through our a) Registered Nurse if available, and b) NP as a back-up. All triaged calls will be completed will have assessment key words within a pre-made stamps, to easily extract data at a later date. 2. All patients deemed appropriate for a same-day visit will be tracked through assessment key words within the same pre-made stamp as in #2. 3. Each month those triaged will be compared to those who required and appointment. 4. Each triage note that requires an appointment will be matched against whether a same-day or next-day appointment occurred.	Percentage of patients who require a same day or next day appointment and an appointment is offered.	60% of patients who are triaged through the registered nurse/NP and deemed appropriate for a same-day/next day will receive an appointment option between April 1 2019-April 1 2020.	
Theme II: Service Excellence	Patient-centred	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92327*	CB				1)				We intend to include this indicator into our work-plan for next year, as we are transitioning our EMR on April 3, 2019, and will not have the capacity during this fiscal year to complete this survey. However, after one year we intend to be able to integrate Ocean into our work-flow in order to have our clients complete a survey to address this indicator.
		Addressing multiple issues in a single visit	C	% / All patients	EMR/Chart Review / 2019-2020	92327*	36	45.00	As nurse practitioners we are able to address multiple issues per visit, which is more holistic and improves client satisfaction in primary care. It also aids to decrease in ER and walk-in visits. Finally this model of care allows complex clients who may have transportation or finance barriers, to decrease visits to clinic, without decreasing the amount of care they receive.		1)At present we are already offering to address multiple issues per visit, however these are not necessarily tracked in a formalized way. We also think we can improve involvement of the registered nurse within an NP visit, to facilitate other priority assessments such as immunizations, screening, and medication reconciliation. At present, as a result of our population, we also see many clients 20+ times per year, which makes it difficult to increase our patient roster. Thus we hypothesize that if we can increase the number of issues addressed per visit, that our per patient number of visits per year will decrease, allowing us to increase the number of patients we can roster.	RN and NP QIP committee representatives will be responsible for this measure. 1. At our organization we have one RN for two NPs. Through RN/NP collaboration it will be determined at the beginning of each day which patients are not up-to-date for immunizations, medication reconciliation, and preventative screening. 2. Each month the number of issues per visit will be tracked per patient seen.	Percentage of patients who have: a) 1-2 issue per visit addressed b) 3-4 issues per visit addressed c) 5-6 issues per visit addressed d) 7+ issues per visit addressed	1) 45% of our patient visits with an NP will have 3+ issues addressed per visit between April 1 2019-April 1 2020. 2) 20% of our patient visits with an NP will have 5+ issues addressed per visit between April 1 2019-April 1 2020.	
		Multidisciplinary primary care	C	% / All patients	EMR/Chart Review / 2019-2020	92327*	30	40.00	Considering the complexity of our population both with respect to mental health, chronic disease, and barriers to access; our clients are less likely to require crisis services, or visit ER or walk-ins if we provide frequent, holistic, and comprehensive care. As such, we intend to increase the number of internal referrals within our organization to our registered nurses, social worker and dietitian.		1)We will be continuing the collaboration with the QIIMS and the other NPLCs in the province to plan an approach, in consultation with both the NPs and IHPs within each NPLC, to most adequately capture the interdisciplinary health care delivery experienced by patients of the NPLC.	Count number of patients who have had at least one appointment in the past year. Calculate the percentage of patients who have seen more than one provider in the past year, specifically identifying the interdisciplinary team work within the NPLC. Meetings will be organized with the QIIMS and the NPLCs to develop appropriate searches, queries or tools that can be added to the EMR to facilitate recording interdisciplinary work on a regular basis.	RN and NP QIP committee representatives will be responsible for this measure. The number of patients who have seen more than one provider (NP or IHP) in the past year. The number of providers an average patient sees in the past year within the NPLC. The number of joint meetings held with the QIIMS and the NPLCs.	40% of all adult patients will receive care by three or more team members including the NP between April 1, 2019 to April 1, 2020. In a team-based setting, patients have access to a range of health professionals, where nurse practitioners work closely with other care providers, like dietitians, mental health providers and physiotherapists. This ensures patients see the right provider when they need it, improving the patient experience, increasing efficiency and avoiding emergency room visits. The initial steps will need to be completed before reporting on this new indicator, but meetings will be held starting in Summer 2019 and searches, queries or tools should be implemented by Fall 2019.	This is an indicator that will be implemented across multiple NPLCs in the province, specifically using the assistance of the QIIMS and to specifically capture the interdisciplinary team work that exists within the NPLC model of health care delivery. Evidence from British Columbia shows that giving a complex patient access to team-based primary care reduces the cost of their care by 60%. AFHTO's Quality Roll-up Indicator shows that team-based primary care exceeds the provincial average when it comes to quality of care and is related to lower health care costs per person.

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	92327*					1)				At present, 100% of our palliative patients are receiving appropriate palliative care.
	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system within a 6-month reporting period.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	92327*					1)				We already excel in this indicator with only 0.27% of all adult non-palliative patients being prescribed an opioid, and only 0.18% of all adult patients being prescribed an opioid long-term. This 0.18% has already been addressed and these patients are now seeing addictions/pain teams.
Equity	**Equitable**	Add other measure by clicking on "Add New Measure"	A	Other / Other	Other / Other	92327*									
		A hepatitis C-free NPLC; Screening Indicator	C	Proportion / All patients	EMR/Chart Review / 2019-2020	92327*	57.2	80.00	Over the last year, the nurse practitioners have screened 57.2% of the indicated population for hepatitis C as per the Canadian guidelines, with a 5% positivity rate among those tested; in comparison to the Canadian national average which is approximately 1%. We believe that increasing our screening rate is possible, and perhaps more importantly, we believe that we can engage those who are positive in care in our practice.	University Health Network	1)Hepatitis C continues to be a highly stigmatized disease where patients continue to feel judged, and therefore do not seek care. At Health Zone, we have already demonstrated that we can successfully treat hepatitis C in primary care, and under an NP-led model. We do know however, that one barrier to identifying infections, is that patients often do not feel unwell until they have advanced liver disease. As such, we intend to case-find those who are infected in our practice.	RN and NP QIP committee representatives will be responsible for this measure. 1. Chart review of all those who meet screening criteria, which has been completed. 2. Contact clients who have not been screened and book for visit, or flag their next visit to incorporate screening. 3. Of those in our practice who are known antibody positive, but never received an RNA, we will have dedicated RN booked days to draw HCV RNA bloodwork. If positive we will engage them in treatment. 4. Of those who are RNA positive, but may or may not have been treated, we will contact the office of the hepatologist/infectious disease physician they were referred to in the past, to either confirm cure, or determine whether they were lost to follow-up. 5. We will treat all those who are chronically infected, whether newly diagnosed or lost to follow-up in specialty care. 6. We will report SVR (cure) rates.	1. To screen 80% of all indicated patients. 2. To treat 90% of all indicated patients.	1. To screen 80% of all indicated patients between April 1 2019-April 1 2020. 2. To treat 90% of all indicated patients between April 1 2019-April 1 2020.	
		Improving mental health monitoring	C	% / Mental health patients	EMR/Chart Review / 2019-2020	92327*	CB	60.00	As an equity-based organization, we prioritize women and children in transition, newcomers, and those with mental health; recognizing the need to provide timely, trauma-informed care. As a result of we serve many individuals with complex health needs who are supported by social assistance. In order to provide the most comprehensive care possible, we therefore closely monitor many individuals with mental health concerns. In fact, in 2018-2019 20% of our adult population was being prescribed one or more mental health medication. We know that these individuals are seen at minimum once every six months. However, this is only half of the patients registered to our clinic with mental health concerns. The other half would benefit from providing "mental health recalls", as is done for many other chronic diseases. Using our new EMR Telus PS Suites we will be able to pull all rostered clients with a mental health diagnosis and determine whether they were reviewed in the last six month, and whether medication or social work involvement is indicated. At this time, we will contact our patients to determine whether they feel they have relapsed or require a mental health follow-up visit.		1)At present, NPs rely on the patient to book their mental health follow-up visit. This change idea will have two mechanisms to improve mental health follow-up.	RN and NP QIP committee representatives will be responsible for this measure. 1. NPs (as opposed to MOAs) will book all mental health follow-up visits one month before the end of their medication refill (length depends on the stability of the client). This will allow the NP to be able to prescribe an additional month should the patient no-show to their appointment (which is common in this population). 2. We will generate a mental health recall list, specifically for patients who have severe and persistent mental health and use the ER often. We will review this list monthly and book patents accordingly.	Percentage of patients who are taking mental health medications that are seen before the end of their prescription for follow-up.	Considering the complexity of our population: 60% of patients who are prescribed mental health medications within the NPLC will be seen in clinic before the end of their prescription between April 1, 2019 and April 1, 2020.	
		Increasing access to primary care for newcomer/non-English speaking patients	C	Number / All patients	EMR/Chart Review / 2019-2020	92327*	127	157.00	Health Zone is one of the only primary care organizations in London that cares for non-OHIP insured clients. Many times, these clients are not fluent in English, or literate in their first language, making communication difficult. We provide translation services in both primary care and specialty care; and do not require an OHIP card for services. However, we are aware that there are many newcomer families who continue to be without a primary care provider in London, ON. We therefore plan to increase the number of non-English speaking clients/newcomer patients in our clinic. We have the capacity to increase our roster sizes and have agreed that serving newcomer patients in London is a major priority.		1)We will collaborate with a current external partner Rotholme Women's & Family Shelter to identify newcomer/non-English speaking patients who are in transition from the shelter to a more stable living situation. If these clients have the ability to access transit to one of our two clinics, then we will offer a primary care spot to a limited number of clients. This indicator is incredibly important, as newcomers without primary care in particular are one of the main users of the ER. Additionally, Canadian studies have revealed that newcomers typically arrive in Canada with less chronic disease issues than the average Canadian, however within 3-5 years of arriving, have worse health outcomes.	RN and NP QIP committee representatives will be responsible for this measure. 1. Each month the staff at Rotholme will identify 2-4 patients who have a moving date. These patients will not previously be engaged with a family physician. The Rotholme staff will do an inventory of the patient's known past medical history and current medications. 2. As appropriate 2-4 patients will be offered an intake visit at one of the Health Zone sites with our RN. 3. As appropriate these patients will then see an NP for intake.	Number of newcomer/non-English speaker patients rostered at Health Zone per year	To increase our newcomer/non-English speaking roster from 127 to 157 patient between April 1, 2019 and April 1, 2020.	These patients typically have never received preventative health screening, and have unmanaged chronic disease and/or mental health. As translation service are also required, NPs and allied health spend more time with these patients. Thus an overall increase in roster size of 30 patients is a reasonable undertaking over a one year period.